Department of Mental Health (DMH)
Mental Health Services Act (MHSA)
Stakeholder Input Process

General Stakeholders Meeting #7

Tuesday, November 14, 2006 in San Diego, California
Friday, November 17, 2006 in Fresno, California

Meeting Summary
For Discussion Only

I. Background

The Mental Health Services Act (MHSA) became state law on January 1, 2005. The passage of the Act has created the expectation of a comprehensive planning process within the public mental health system. The multiple components of the MHSA are designed to support one another in leading to a transformed culturally competent mental health system. This is reflected in the California Department of Mental Health's (DMH) *Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act* of February 16, 2005: "As a designated partner in this critical and historic undertaking, the California Department of Mental Health will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families. In its implementation responsibilities under the MHSA, DMH pledges to look beyond "business as usual" to help build a system where access will be easier, services are more effective, out-of-home and institutional care are reduced and stigma toward those with severe mental illness or serious emotional disturbance no longer exists."

The general stakeholder meetings on November 14 in San Diego and November 17 in Fresno were the seventh set of general stakeholder meetings for MHSA. Both meetings used the same agenda.

Fifty people attended the meeting on November 14 and 69 attended on November 17 for a total of 119 stakeholders. This summary reflects the combined content, questions and comments from both the November 14 and November 17 meetings.

II. Welcome, Introduction and Purpose of the General Stakeholders Meeting

Bobbie Wunsch, Pacific Health Consulting Group and facilitator of the MHSA stakeholder process, welcomed the participants to the seventh set of general stakeholders meetings. She described the purpose of general stakeholder meetings: they are meant to update the community about progress on MHSA at the state level and to solicit feedback from stakeholders on three aspects of the MHSA. Feedback from participants would be solicited in three ways: through question and answer periods in the large group, small group discussions in Technology and written comments on Capital Facilities and Technology.

The purposes of the general stakeholder meetings on November 14 and 17, 2006 were to:

1. Report on progress on Health Information Technology

2. Provide updates on Capital Facilities and Housing

3. Provide updates on new MHSA revenues

III. Presentation on MHSA Technology Update

Gary Renslo, DMH Chief Information Officer and Stephanie Oprendek, Acting Chief, Evaluation, Statistics and Support, presented an update on the progress of the Technology component of MHSA and then sought input from participants on key questions. They took the title of their presentation from Goal Six of the President's New Freedom Commission Report on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*: "In a transformed mental health system, technology is used to access mental health care and information." Communities have been experiencing substantial momentum in development of Health Information Technology (Health IT).

MHSA Technology Funding: A Catalyst for Change

- The MHSA specifies funding for technology needs
- This funding facilitates health technology transformation by supporting four core areas:
  1. Mental Health Electronic Health Record (EHR) Systems
  2. Mental Health Information Exchange (HIE)
  3. Telemedicine
  4. Infrastructure (computers, wireless PDAs, telecommunications, etc.)

MHSA Technology Requirements

Through earlier stakeholder and workgroup meetings, DMH had identified specific needs important to stakeholders in the arena of technology. These needs fall into two

areas: mental health information system functions and attributes – how systems can utilize health information and what information the system can produce**.**

Mental Health Information System Functions

- Enable medical record annotation and correction
- Schedule appointments, refill prescriptions, view lab results
- Enable access to providers and clinicians
- Enable services reporting/feedback for quality assurance for services
- Provide access to all legally allowed information (as is now on paper)

Mental Health Information System Attributes

- The system has to be secure, ADA compliant, culturally competent and must operate in real time
- The system must be accessible through public computers, broadband access and rural access. This could include computers located at peer support centers and wellness and recovery centers.
- The system must have clear authentication/authorization processes for each access level

MHSA Technology Goal (Draft)

To transform the county/local mental health technology systems into an accessible, interoperable, comprehensive information network that can:

- Easily and securely capture, exchange and utilize information
- Facilitate the highest quality, cost-effective services and supports for consumer and family wellness, recovery and resiliency

National Context for Mental Health IT Work in California

- Mental Health is an integral part of personal and public health. All levels of government and service need to involve their communities and integrate services. The same is true for Health IT and HIE: DMH and county mental health agencies need to understand how Health IT and HIE work in an integrated way. Mental health stakeholders need to be involved in the process, because mental health is somewhat different from physical health, in terms of wellness and recovery goals.
- The Hurricane Katrina disaster sparked interest in electronic records, when many paper records were destroyed.
- The public health issues of pandemic flu and potential bioterrorism require tracking through technology to assure that people could obtain services as soon as possible.
- The cost of healthcare continues to skyrocket: expenditures rose 7.2% in 2004. The expenditures are expected to double by 2015 and reach 20% of the Gross Domestic Product of all goods and services produced in the country. Technology can help decrease these growing costs.
- Active involvement of consumers in health and healthcare: the only way to embrace recovery as well as slow costs is to involve consumers in participating in their health care.

Health IT is Gaining Significant Momentum
It is important for California to be part of the Health Information movement.

Federal/National Initiatives Regarding Health IT Advancement

- The President's goal of widespread adoption of interoperable electronic health records with Executive Order 13335 (2004), which established the Office of National Coordinator and the National Health Information Infrastructure
- Office of the National Coordinator for Health Information Technology
- Department of Health and Human Services initiated activities, through American Health Information Community (AHIC), Agency for Healthcare Research and Quality (AHRQ), Rural Technology Initiative (RTI) contacts, National Governors Association (NGA) strategies, and Medicare transformation grants – pay for performance, etc.).
- The President's New Freedom Commission on Mental Health technology goal and recommendations. Published in 2004, these include goals about telehealth to improve access to information as well as the development and integration of personal health systems.
- The Institute of Medicine has a quality strategy of rapid IT and performance measurement.

Electronic Health Record (EHR) and Health Information Exchange (HIE)

DMH is participating in a number of efforts to establish standards for EHR and HIE.

National Efforts

- Health Level 7 (HL7) and the Healthcare Information Technology Standards Panel (HITSP):
  - HL7 and HITSP are working on EHR and interoperability standards and specifications and a conformance profile for behavioral health. The Substance Abuse and Mental Health Services Administration (SAMHSA) of the US Department of Health and Human Services (DHHS) is coordinating this effort.
- The Certification Commission for Healthcare Information Technology (CCHIT) is developing a process for EHR vendor certification.
- California Health Information Security and Privacy Collaboration Project (HISPC):
  - HISPC is reviewing the different standards and working to bring them all together into a set of standards for interoperability. It seeks to assess and develop plans to address variations in business policies and state laws that affect privacy and security practices that may pose challenges to interoperable HIE. One scenario is to obtain the laboratory results from the laboratories directly rather than through the ordering clinician.
- Nationwide Health Information Network (NHIN) Consortia:
  - The NHIN Consortia are working to develop an architecture and a prototype network for secure information sharing among hospitals, laboratories, pharmacies and physicians.
  - These consortia will test patient identification and information locator services, user authentication, access control and other security protections.

- Regional Health Information Organizations (RHIO):
  - RHIOs address interoperability and health information exchange architectures. These organizations have been building collaboration for internal business practices.
  - These organizations started as grassroots efforts to promote interoperability.
  - California's RHIO is called Cal RHIO.

Governor's Executive Order S-12-06

The Governor issued Executive Order S-12-06, which mirrors the national directive and provides leadership on Health IT.

Health IT Vision

- Achieve 100% electronic health data exchange among payers, providers, consumers, researchers and government agencies in the next ten years.

Health IT Mission

- Provide Californians with appropriate personal health information available in a timely and secure fashion and enable affordable, safe and accessible health care.

Health IT Goals

- Ensure health information is available at the point of care for all consumers while protecting the confidentiality and privacy of the information.
- Improve safety, reducing medical errors and avoiding duplicative and unnecessary medical procedures.
- Improve coordination of care among hospitals, clinics, skilled nursing facilities, home care agencies, pharmacies, physicians and other health professionals (e.g. mental health).
- Provide consumers with their own health information to encourage greater participation in their health care decisions.
- Ensure access to specialists in a more timely manner for rural and underserved areas through technologies such as telemedicine.

Alignment of Federal and State Health IT Action Agendas

California is closely aligned with the national efforts, and all are moving in a very positive direction. The close alignment can be seen below.

President's Health IT Plan	**Governor's Executive Order**
• Standards harmonization • Compliance certification • Privacy and security solutions • Nationwide health information network architectures • Health IT adoption	• Adopt/align standards • Augment current privacy protections • Develop California Health IT infrastructure and resources • Establish incentives and requirements to expand Health IT adoption • Establish governance • Engage stakeholders

State and Local Government
California Government Committee on Health Information Technology (CGC Health IT)

Approximately six months ago, California started the CGC Health IT to facilitate the collaboration of State agencies and local governments on Health IT and HIE related business needs and efforts.

The CGC Health IT will:
- Develop an understanding of the requirements of Health IT and HIE systems within the State of California.
- Share information about Health IT and its impact on state and local government.
- Support the action items identified in Executive Order S-12-06 by leveraging Health IT efforts at all levels (federal, state, local and private sectors).

The group is in its charter stage and hopes it will be an ongoing workgroup to coordinate efforts between the State and local entities.

The MHSA IT Group is comprised of:
- Mental health services consumers, family members and parents
- Organizations representing consumers, family members and parents
- Mental health services providers
- California counties, small, medium and large
- Currently contracted county IT vendors
- DMH

Stakeholders and Partnerships Bringing about IT Transformation
A transformational mental health information system must address:
- Technology, content and functionality standards
- Secure interoperability and integration
- Flexibility for business changes

Components of local/county mental health information systems:
- Claiming and costs information
- External lookups and alerts, such as medication interactions
- Allied agency interface (ADP, Health, CDSS)
- Access to information and service networks so that people can find the right services
- Cross-county and county-state interoperability so that information can be exchanged
- Outcomes and standard data reporting
- Decision support functions
- Continuum of services interface
- Workforce information, to make sure the mental health workforce matches the people who need services

To facilitate this architecture, DMH will be releasing two Requests for Information (RFIs). One is for the EHR system and one for the HIE agent. They will be developed for concurrent evaluation.

The Mental Health Information Agent would interconnect the systems. In HIE, information passes through the agent from one entity to another using standard data and secure exchange protocols. With the agent, different EHR systems do not need to create exchange protocols with every other system. Rather, each communicates through the agent in a standard way to share information. Hospitals and emergency departments, laboratories and pharmacies and "My Health Folder" could all access information through the Information Agent. Data repositories could also be part of this process.

RFI (A): The EHR System

This RFI will determine vendors interested in providing EHR systems in California based on:

- The EHR Functional Model/the Behavioral Health Conformance Profile
- The California Behavioral Systems Coalition Request for Proposal, which was released by CIMH several years ago
- The Continuity of Care Record/Clinical Document Architecture, the core level interoperability fields

RFI (B): The HIE Agent

This RFI will determine vendors interested in providing interchange functionality for interoperability between counties and other entities based on:

- The capacity to transfer the Continuity of Care Record/Clinical Document Architecture
- Master Patient Index/Record Locator Service: how to uniquely identify an individual
- Personal Health Record – "My Health Folder" which will allow consumers to access personal health information

RFI Vendor Validation

Vendor validation will develop a summary validated vendor information sheet to inform a provider or a county, taking into account:

- Functionality percentages
- Reference check summary
- User experience reviews
- Ease in customization
- Financial viability of vendor
- Hardware and licensing requirements
- Other criteria defined in the stakeholder process

Funding Request

- California counties will submit Technology Funding Requests in response to the DMH requirements.

- DMH will review the requests and work with each county for any required clarifications/modifications.

Post-Funding Technology Plan Oversight

- Upon approval of each request, DMH will continue in an oversight capacity with each county to help ensure the success of the MHSA projects. DMH is currently doing this review with the CSS one-time-only projects.

Next Steps

- DMH will work with stakeholders to:
  - Define and prioritize technology needs and the minimum requirements for EHR/HIE systems
  - Address Health IT action areas
  - Develop two RFIs
    - RFI (A): The EHR System
    - RFI (B): The HIE Agent
  - Perform vendor evaluation
    - Develop a validated vendor information sheet
- Develop county plan technology funding requirements

MHSA IT Contact Information

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Stakeholder Comments and Questions on Technology

Consumer Participation and Access

- **Stakeholder Comment:** Clients need computer and internet access and some also need computer literacy training, in order to seek housing or employment, write resumes, access their own EHR, create and sustain client-run programs and stay informed of upcoming MHSA meetings and information. Yet many clients live in poverty and lack sufficient access to computers and the Internet to perform these basic tasks.
- **Stakeholder Comment:** Clients must be allowed access to their own electronic health records, in order to make informed choices in their recovery.
- **Stakeholder Comment:** Print-outs, data CDs or DVDs should be provided to clients within four days upon request containing their complete EHR from the past five years, or as far back as the records go. Older records that have been transferred to electronic format should be made available to clients on request as print-outs, data CDs or DVDs within two weeks.
- **Stakeholder Comment:** In order to conserve paper and the environment, each client should be issued a free one gigabyte flash drive upon request, which may be

substituted for print-outs, CDs or DVDs and updated periodically with new medical records in addition to older ones. If this flash drive is lost, the client may still receive print-outs, CDs or DVDs of their records.

- **Stakeholder Comment:** At stakeholder meetings, the DMH has thus far focused on using IT funding to pay for new computer systems and networking infrastructure for county mental health departments as they transition from paper to electronic health records. This focus has largely ignored the digital divide and low income clients' need for computers and Internet access. Also neglected at these meetings are issues of clients' access to their own electronic health records and clients' concerns about the privacy and security of their electronic health records.
- **Stakeholder Comment:** In addition to the set-aside for computers, consumers need to be trained to participate in the process, and boost consumer participation. MHSA should dedicate more funds for participation of stakeholders.
- **Stakeholder Question:** Is this about clients' own personal computers or public computers?
  - **DMH Response (Gary Renslo (GR)):** DMH is considering computers at public sites for client use.
- **Stakeholder Question:** Will individual consumers have a choice about having their information in an electronic format?
  - **DMH Response (Stephanie Oprendek (SO)):** Once EHRs are widely available, it is unlikely that providers will use paper-based charting.
- **Stakeholder Comment:** If a consumer's records are electronic, that person should have 100% access to those records, and a glossary of terms that appear in the records.
- **Stakeholder Comment:** There should be consumer representatives on the technology committee.
- **Stakeholder Comment:** It's hard to know how this technology helps people become independent, and move from supportive housing to independent housing.
- **Stakeholder Comment:** Many mental health clients live in poverty and lack access to computers, the Internet and computer literacy training. Public libraries do not offer sufficient computer access for most people without computers or computer literacy training who are seeking housing or employment, writing resumes, accessing their electronic health records, creating a client-run program or keeping abreast of upcoming MHSA meetings and information.

County Funding of Consumer Technology Needs

- **Stakeholder Comment:** The MHSA is transformational and promotes thinking outside the box. Require that ten percent of the Technology funding for counties be spent to provide computers to consumers, especially consumer leaders.
  - **DMH Response (GR):** Some of the initial funding requests have already included funding for computers for consumers. DMH has not yet determined how much funding in Capital Facilities and Technology needs will be dedicated for Technology vs. Capital Facilities. DMH will consider requests from counties that include funding for access to computers by consumers.

- **Stakeholder Comment:** Counties should be required to allocate at least 10 percent of their IT funding for the provision of computers, Internet access and computer literacy education to clients in community settings.
- **Stakeholder Comment:** One or more full-time introductory computer literacy instructors should be hired in each county to teach regular computer literacy classes for clients at computer and Internet equipped self-help, wellness and community centers throughout the county. These instructors should be bilingual and fluent in one or more threshold languages that are spoken in each county.
- **Stakeholder Comment:** One or several laptop computers should be purchased with these funds and made available to client leaders in each county who attend local MHSA meetings and network with other clients to encourage them to become involved in MHSA planning, implementation and evaluation.
- **Stakeholder Comment:** Many new personal computers and broadband Internet connections are needed in client-run self-help and drop-in centers, wellness and recovery centers and community resource centers in each county for clients to use. Centers with MHSA-funded client computer labs should post flyers in public places, advertise in local newspapers and conduct some community outreach, such as visits to local mental health programs for youth, adults and older adults.

County IT Development Issues

- **Stakeholder Question:** Is there a timeline for the standards release?
  - **DMH Response (SO):** DMH expects to release them in January 2007 or soon thereafter.
- **Stakeholder Question:** How does DMH envision this system working with counties that are in process of expanding their IT?
  - **DMH Response (GR):** DMH will set minimum requirements. Once counties have met those requirements, counties can ask for money for different or additional IT needs.
- **Stakeholder Question:** If a county has already implemented some of the requirements, will there still be IT funding available for them?
  - **DMH Response (GR):** Counties can request additional funding for different areas of IT needs, if they have already met the requirements.
- **Stakeholder Question:** For a small county, this architecture may be too burdensome. Such counties might create a system before the standards are released that will not work with these standards. Will there be coordination with the work that has been done already?
  - **DMH Response (SO):** DMH has found that no one system is perfect. It is better to have different systems that can be made interoperable.
- **Stakeholder Question:** How is this architecture different from the tested model in Santa Cruz County?
  - **DMH Response (GR):** The development process has been an incremental one. IT people learn from each model across the nation and grow to a new level. It is similar to Santa Cruz.
- **Stakeholder Comment:** Fresno County Mental Health has experienced many issues, including budget shortfalls. Its IT systems are limited and do not allow access to timely information or linking clients to their funding. It has worked with

DMH to change this and DMH has been very helpful. As one result of DMH help, Fresno County Mental Health has released an RFP for integrated mental health information, and vendors have responded.

- **Stakeholder Comment:** This system should interact with the Network of Care, in which DMH has already invested.

Privacy Issues

- **Stakeholder Comment:** Concrete steps must be taken to ensure that privacy and security of electronic health records databases are maintained so as to prevent clients' mental health records and other private information from being accessed by unscrupulous landlords, employers, insurance companies, abusive partners and others who may seek to access this information without permission from the client. Databases containing electronic health records must be secured against hackers and viruses. Law enforcement officers, primary care providers and other non-mental health service providers should not have unrestricted access to clients' electronic health records. Access should only be granted with permission of clients themselves.
- **Stakeholder Comment:** The DMH Capital Facilities and IT must require counties, which use IT funds to convert paper health records into electronic format and to build EHR databases, to ensure that clients are allowed access to their personal EHR and that the privacy and security of these electronic health records are not compromised in any way.
    - **DMH Response (SO):** These are the issues DMH is addressing. DMH will be soliciting stakeholder input on how to get counties involved in EHR and confidentiality of records.
- **Stakeholder Question:** Does DMH plan to build separate booths at the actual physical facilities? For example, at libraries as they are generally configured, someone could easily gain access to someone else's records merely by looking over their shoulder. Passwords are not as secure as they could or should be. This could be very risky.
    - **DMH Response (SO):** The system needs to protect consumer information.

RFI and Funding Concerns

- **Stakeholder Comment:** The RFI step is good. It is important to choose partners very carefully when buying telecommunications systems, for hardware and software. Require vendors to partner with others and assure that they are competent and have the capacity to support their products.
- **Stakeholder Comment:** San Diego County does not provide physical and mental health itself, but contracts with private providers. The community providers are trying to better integrate physical and mental health and are in the midst of a project to do this for children with severe emotional disturbance. The community clinics are in the process of developing an EHR product, which would support MHSA. How the money is distributed is important. DMH should include partners, not just county government, by setting aside a portion of funding for other community partners that are delivering mental health services.

Concerns about IT

- **Stakeholder Comment:** All this money for IT seems excessive: buying new pots and pans when the kitchen has no stove. Money should go to services and housing.
- **Stakeholder Comment:** Make sure that counties do not have to take money from program services to pay for IT.

Small Group Discussions on MHSA Technology

Stakeholders gathered in small groups to discuss some key questions relating to IT.

Question 1. To accomplish the vision of county Health IT systems that can be fully interoperable statewide, it is critical that all counties participate and move toward this goal. Please provide suggestions on how to provide incentives or establish requirements so that all counties have this as a priority.

Incentives

Financial Incentives

- MHSA should only provide funding if systems are able to link into the statewide/county system. The county system does not have to be interoperable initially, but should become so as other counties come on-line.
- Accountability means that funds follow results
- Make sure that counties that receive money follow the mandates
- Funding could be an incentive to achieve interoperability
- Integration of system improvements could lead to additional funding
- Offer additional funding possibility for earlier implementation
- Show that funding equals management support
- Loans, cash and other funding sources
- More money
- It seems that counties are short on staff and/or short on money. A good incentive might be for DMH to fund staff positions that would be trained at these specific IT issues and would work with each county or at each county to facilitate the process and ensure compliance.
- Provide flexible funding
- Provide funding for up-to-date equipment and technical staffing
- Cost-savings is an incentive
- One incentive could be that counties could use the cost savings from IT efficiencies for direct services

Specific Incentives

- Promote interoperability because it has potential for saving lives
- This is comparable to the educational system. Every child in the state has a number. An incentive was given in the form of innovation grants from the state and federal governments. Security is within the system and vendors.
- DMH could give incentives to engage those counties that are not participating in the stakeholder process
- Provide universal software

- Medical school experiences with Department of Psychiatry might add good practice more easily and would identify mistakes, and improve quality of care
- Entice counties by connecting current issues to proposed MHSA goals
- Educate consumers to go to counties: ID cards for consumers with access and services. Incentive would be consumers asking for this.
- DMH could publish best practices for development and implementation of systems
- DMH could facilitate visits to counties that have successfully implemented interoperable systems so that counties can share experiences
- Show staff how computers enhance time management by simplifying staff tasks
- Provide creative examples to counties, such as leveraging other funds with MHSA funds for satellite connectivity. Rural challenges are around infrastructure.
- Back-ups would be available, guaranteeing no loss of information
- Show that this system would provide better communication with providers
- Use carrots, not sticks

Training and Technical Assistance Incentives

- Provide ongoing funding for technology training to enable participants to engage in EHR activities such as Cal RHIO. Train county IT staff on EHR and technology.
- Provide incentives for health care professionals to seek Health IT and EHR training
- Motivate staff and providers to use the system, with computer training and access to computers
- Conduct brainstorming sessions with staff on technology barriers
- Provide incentives and training money
- Cross train IT, mental health and physical health in HIE
- Offer technical assistance
- Provide technical support to counties to understand how to write the IT plan. Provide examples of approved plans.
- Provide funding to participate in regional groups, trainings, workgroups and standards development
- "Knowledge is power": More information is needed to all service providers. Reach out to all.

Requirements

- Mandate interoperability with a set time for implementation
- What is meant by the Executive Order? If it is an order, then why would counties need an incentive?
- Have clear regulations that hold county governments accountable for regulations of MHSA
- Make it mandatory for counties to have a system

Consumer Access and Buy-In

- Require counties to use 10% or more to provide computers and internet access to consumers in the community
- Include personal computer access to clubhouses, one-stop centers, etc. Enhance funding to existing personal computer access points such as libraries and community centers.

- Clients would benefit greatly if they know that they would have safe EHRs they can access. Photo ID cards would give clients access to the system.
- Offer greater computer access for consumers
- Develop a glossary to support people's understanding of what is written about them
- Change the fragmented system so that consumers are all on board and can easily access the system
- If clients want EHRs, that will promote it to other stakeholders: service providers, other departments and the public
- Make use of the Network of Care by connecting EHR to the Network of Care
- Community-based education: start process with consumers and outreach and build from there. DMH and counties can use empowerment of accessing information and services as a selling point.
- Our county has a replacement/modernization program for its computers and makes the discards available to clients
- Computers give access to many subjects, which is good
- Make sure the system that consumers use is user-friendly
- Open an internet café
- Allow consumers to download music
- Allow consumers to access email
- Not all computers at wellness centers work
- Lots of people resist the use of computers
- Some consumers will not want access
- Consumers do not see IT expansion as a good goal

Consumer Security/Privacy Issues

- Security and privacy issues must be addressed before interoperability
- Security issues between counties and between agencies within counties need to be looked at more carefully before interoperability, such as information access by landlords, insurance companies, abusive ex-partners, employers, etc.
- There is a primary concern regarding who can access medical information
- Use Network of Care Website standards of security
- Find ways to designate what parts of records can be viewed and by whom
- Go directly to clients, to reassure them about security issues
- Generalities are fine for computer access: library availability, media orientations, but personal/privacy matters are different and must be addressed
- There are barriers and generally held stigmas to overcome. Worry about hackers: non-privacy, confidentiality and secrecy
- Consumers request the ability and right to not have their information released without their permission or request. There must be a release of information form to release information to any outside entities.

Transition Age Youth

- Transition age youth have quick turnaround time with learning computers and Internet skills. However, they may not be used to making informed choices about their health.

- There is a benefit to reaching young people because they are quick learners and may have buy-in and feedback sooner.
- Training could be provided to consumers to use computers. Connect young adults to older adults who do not have computer experience. The youth could earn community service hours.
- There are parallels with student records: students did not want Army recruiters to be able to access student records.

Consumer Training

- Start with transition age youth, adults and older adults
- Educate consumers to go to counties: ID card power for consumer with access and services. Incentive would be consumers asking for this.
- Educate clients to make computers user friendly
- Recruit and hire consumers to provide peer-led instruction in use of computers
- Computer access and training should be available at wellness centers
- Other clients can help with training

Standards, Data and Architecture

- Develop metrics based on recovery
- Use standardized data, data definitions or outcomes
- Will this result in a statewide registry between DMH and counties? If a client moves to another county, will their information follow them electronically?
- Counties need to provide providers with the ability to electronically exchange information
- Architecture is good as long as standards are followed
- Establish standards and publish them across counties to use in submitting proposals and plans for budget requests
- Accelerate determination of standards and get these to vendors as soon as possible
- Develop general standards based on existing standards in other highly secure realms
- Standardize operating systems and software so that all counties are on the same page
- The standards must be consistent with good technology and with health care recordkeeping policy and legal requirements
- DMH needs to provide detailed requirements for the standards the vendor must meet
- Require counties to follow consistent standards for the information and processes implemented with community-based providers. Providers operating in multiple counties have great difficulty maintaining or developing systems to meet the variety of requirements. Requirements though consistent at the state level are many and varied amongst counties.

Integration with Other Health Systems

- Obtain buy-in from public health, clinics and programs associated with those business areas

- Address records stewardship and custody and present health care providers and organizations with plans that meet legal requirements
- DMH should review systems other than behavioral health systems. Explore physical health services.
- Current medical systems do not have mental health "flavor" and mental health systems do not have physical health characteristics
- Make sure jail, prisons and law enforcement have prompt and current access to consumer medical records including medications
- Have physical health providers been consulted? Not all groups seem to be discussing these issues.
- Is funding available for public health systems? Integration?
- Where is this approach working in our country?
- How does the VA handle this? The military? Can we learn from them?

County Buy-In

- If it is voluntary, there will be counties who choose not to cooperate
- Counties may or may not want to buy into this. If counties participate, it must be interoperable.
- Insure counties have "bought in" to this process. Each county should be required to have an IT person.
- Many counties feel the large counties "drive" the process due to large funding
- If DMH wants the county to make it work, then ask the county for input
- If a county does not apply, what happens?
- Modoc County needs high speed Internet and had to purchase a satellite system or dish

Planning Time and Technical Assistance

- Provide timeline for all counties to reach statewide interoperability
- Assume planning time for stakeholder input and buy-in for EHR systems
- Take the time to do proper planning, having all parts organized prior to implementation
- Provide technical assistance to make the transition
- Have DMH provide technical assistance so counties do not have to pay for it
- Registries for information as well as problem-solving procedures would help

Concern about IT Priorities

- Why start with inter-county interoperability? Why is this so important?
- Focus on consumer recovery rather than health IT efforts
- Focus on internal mental health and consumer buy-in to security first
- Focus on consumer buy-in first and then interoperability
- Update antiquated equipment for clients. Provide service to keep systems operable. Make high speed Internet access available without a time limit or restricted access.

Stakeholder Process

- Create local technology stakeholder process

- Counties should require vendors to participate in the stakeholder process as part of their contract
- Mandate counties to have a stakeholder process that is representative of consumers

Vendors
- Develop an approved list of vendors
- Clarify the vendor list quickly with solid interoperability
- Vendors are missing from events such as this

Oversight
- Provide clear and precise direction and real oversight
- How are things being tracked over time, not just medical records, but services?

Question 2. In addition to physical and electronic safeguards, access logging and role-based views, protecting health information requires appropriate authorization and authentication processes.

- **How should a consumer obtain access to his or her health information?**
  Concerns
  - Counties and DMH should do their utmost to hold confidentiality
  - DMH and the county have to make sure the system is secure
  - Protection is very important
  - DVDs, CDs, printed copies have their own security shortcomings: loss, theft, etc.
  - Do not create a new system. Many secure systems exist.
  - There needs to be technical support at libraries, health centers, county mental health offices, etc.
  - When DMH or the county loses a laptop, what do they do to contact consumers?
  - There is concern over the potential of breach of confidentiality. There must be restricted means that only the consumer can get the information.
  - Consumers expressed a great deal of concern about unauthorized access to their mental health information
  - Allowing people to have personal access is very risky
  - This requires a high level of sophistication of computer access for consumers and training for consumers: encourage consumers to become computer literate
  - Automatic log-out is a concern at centers
  - Consumers may not wish their provider to know access code

  Models
  - Use a system like banking models
  - Use the current banking model with encryption features
  - It should be encrypted
  - Require two people or two pieces of identification (ID) to agree to get into data
  - Banks use two IDs, including a library card
  - Work like a safe deposit box for which two people have the key
  - Require multiple pieces of identification to access, not just user ID and password
  - Use Kaiser model in which no card is needed

- Use scan code on a card that consumers carry
- Use smart cards
- Use token systems
- Consumer gets access via writing
- Use designated representatives for families assisting family members
- Use electronic signature

Passwords

- People should create their own passwords online
- Use a system similar to online banking with password and PIN number. What about passwords and PIN numbers written by consumers?
- Use temporary identification and change password during first use
- Passwords should be applied for in-person and in writing, so email or paper is necessary and consumers should be provided with a temporary ID derived from existing records for initial log-in
- Use password and question
- Create and maintain password
- For general information no password is needed. Put on separate computer from EHR.

Access

- Put computers and Internet in places where clients live, as well as drop-in centers, etc., so that they can access outside of group homes, etc.
- Assure public access to computers, at libraries, etc.
- Consumers should only be able to access personal information within the mental health system (mental health office, wellness center, peer support), not from their home computer or public library. People should go to a central location to access records.
- It should be at different levels, for example, the public can only enter certain sites
- Require booths in public places to provide privacy
- Access should be available at both public sites and home sites
- Consumers should be a security group within the system matrix. Organizations should define the sections of records consumers can view, add and edit.
- Have system cater to the consumer and have site key so person can recognize log-in. Use the same system as banks and assure that it is ADA compliant.

Personal Approval

- Ask (via telephone) for information such as address, zip code, using a triple check process
- In-person with an insurance card
- Initial set-up face-to-face and change face-to-face
- Create a password in person. Only the client can assign and change the password unless the individual is on conservatorship.
- In-person wherever consumer is in the community
- Use personal verification: someone agrees consumer is who she or he says she or he is

- Must be in-person and person must prove who she or he is
- Person on a phone could be anyone and therefore access has to be strict

Biometric Features

- Fingerprint recognition
- Use fingerprints or other biometrics
- Voice is non-duplicative
- Biometrics on laptops or public systems (thumbprint is identification or access indicator)
- Hand scan to access records or finger scan with a password

On-Line

- Have access code on a computer
- Personal computers, laptops, etc. How can these be given to consumers?
- Written authorization (legal protection), the best Website so far
- On-line registration for account. PIN to go one step for those to access medical records or treatment information. PIN delivered via mail and can be changed by consumer on demand.
- Have touch screen for clients to navigate

- **Is a User ID and password sufficient to authenticate access to one's health information?**

Concerns

- Cards are not good, because they get lost and do not permit access in public places
- User-based systems wear out and need ongoing and costly upkeep
- Do not mandate solely based on criminal potential; criminals can always find a way
- Too easy to hack
- Passwords and user ID can be hacked into
- Many will not reveal intimacies of all sorts
- User ID is not sufficient
- Ask for mother's maiden name; this might be too difficult
- Consumers should be able to know who has accessed their records
- There need to be safeguards

Methods

- It should be like any other person to access records
- Issue an ID card
- Specific authorization should be the rule
- Use a three-check system
- Provide more than one way to gain access
- Medi-Cal ID number should be required
- Have more than password and ID, but not sure what
- Recreate option for passwords because consumers may forget

- Password should have limited life. Every time they want to access, they should get a new password
- Use a smart card
- Require multiple pieces of identification, not just user ID and password
- Require an additional PIN number on a second screen
- There needs to be a specific check such as certificate or token or based upon more than name or name and date of birth
- Authentication should be based on the context of relationship to client or patient

Biometrics

- Many people have problems with fingerprinting for identification
- Back up with thumbprint
- Thumbprint and/or eye scan
- Fingerprint may work

- **How should a consumer authorize family or various providers to see his or her health information?**

Methods

- Create new account
- Family members are listed in the health record and they just have to show ID
- This needs to be real time
- Have passwords and back-up passwords to Biometrics
- Give a trusted person a thumbprint or access code. (Have two methods.)
- Consumers should be able to provide organizations with at least three pieces of ID validation for family or others to have access to their medical records
- Authorization process should be on-line
- Use of separate sign-in (user name and password) that is controlled by the consumer
- Separate passwords
- Maintain a log of access to consumers
- HIPAA release should go into the system so that not all providers can see information unless release of information is available

Restrict Access

- Limited information role based view
- Install restricted access for different individuals or agencies with varying levels of access
- Have different levels, as with the Network of Care
- Clients should have approved authority for each instance of request for access
- Personal choice only, in writing
- Consumers should be consulted and have approval or disapproval rights for all requests to access their mental health information
- Do not allow providers to override access security
- Provide a way for consumer to cancel access by others (individually)

Learn from Others

- State and federal law already deals with this process
- Access to family members is completely different than access to providers. Providers have established guidelines.
- Look at protocols for other systems for such functions as Corrections
- Is there anything to be learned from the prison system locally or statewide?
- Review advance directive information

Release Forms

- Written consent
- Signed scanned-in release form
- Standard release of information, but with a more effective use

Concerns

- There is potential that an insurer may review prior medical history and deny insurance based on past mental health diagnosis and medication
- This is a 'Catch-22': we want to encourage people to seek treatment and services but then endure possible stigma and labels
- Hold off implementing this feature until improved technology for security is available
- NAMI already experiences challenges and difficulties in this area

Health Care Agent

- Consumers have the legal right to designate a substitute decision maker, a "health care agent" as named in the California Advance Health Care Directive, and can put this person in place immediately. This gives the agent access to the consumer's doctors, medical records, hospital, locked facilities and access to the computer information.
- It is important for the consumer to name a person to be a substitute health care agent for access

Stakeholder Feedback on MHSA Mental Health System Functions and Content

MHSA IT Functions

Stakeholders were asked to identify the top four mental health information system functions a consumer would use to manage his or her own health care and recovery. The functions below are ordered by number of times they were identified, with the number following in parentheses. Stakeholders were also asked to add any other functions that they considered missing from the list.

- Refill prescriptions (55)
- Schedule appointments (53)
- Access to "My Health Folder" (47)
- View lab results (29)
- Enable access to providers and clinicians via email (20)
- Annotate and correct medical records (20)

- Enable services reporting and feedback for quality assurance (11)
- Enable access to providers and clinicians via telemedicine (7)

Stakeholder Feedback on Other Functions

IT Functions

- Access to consumer updates
- A mental health file
- Access to consumer advocacy information and support groups
- Access to consumer support groups via email
- Access to information about disorders from the web
- Linkages to other services such as primary care clinics, vocational rehabilitation, etc.
- The right to privacy
- On-line help that is ADA-compliant and culturally competent
- Better access to self-assessment tools and to community standards on care for conditions and full medication and prescribing information
- Calendar of events for social opportunities with other consumers
- Listing of affordable housing with supportive services, housing subsidies and jobs
- 100% access to everything in the health record
- Listing of services to help consumers understand and complete paperwork, such as SSI, Medi-Cal, etc.

Other Issues

- IT should not be a priority at this time
- Consumer computer training and email should be mandated by DMH
- Accountability for anyone who decides to open a non-licensed home for consumers
- The right to say yes or no to this program
- A facility for socialization, interaction, peer involvement and usefulness
- Educate consumers as to how and why electronic systems improve care and access to services
- Cultural competency

MHSA IT Content for "My Health Folder"

Next, stakeholders were asked to identity the top seven content items they would want to see in a secure, on-line, readily accessible "My Health Folder." Feedback was requested specifically from consumers, family members and providers. Consumer and provider choices are identified below.

Content	Consumer	Provider	Total
Medications	30	31	61
Diagnosis	25	26	51
Allergy and adverse reactions	20	24	44
Lab results	25	14	39
Emergency contact information	17	20	37
Treatment list/prior services	11	25	36
Illnesses and hospitalization	19	13	32

Content	Consumer	Provider	Total
Family history	17	15	32
Current insurance coverage	9	15	24
Surgeries and other procedures	7	5	12
Vaccinations	8	4	12
Current employer	4	1	5

Stakeholder Feedback on Other Content Items

Content

- Steps to wellness plan
- List of supporting friends
- Record of client grievances registered with service providers or counties
- On-line help that is ADA-compliant and culturally competent
- Completion of specific forms, such as Notice of Privacy Practices, consent and release of information to assist in repetitive inquiries
- Information on illness that focuses on teaching consumers about illness rather than just giving medication
- Both the name of any prescribed medication and the reason for the prescription. For example, Prozac can be for pain or depression and the user should know which it is for.
- All information related to gaining entitlements, such as conditions that may qualify a client
- Direct access to primary care provider and community health centers
- Written information about client's illnesses: pamphlets, literature

Other Feedback

- Revise the language from "information technology" to "information and communications technology" to make it clear that the technology helps clients network and communicate
- How will DMH address non-computer literate groups? Having access to computers does not necessarily mean they will know how to use them. Will there be free IT training to communities? How can advocates help considering issues of confidentiality? These issues must be addressed in order to not exacerbate existing health disparities related to access.

IV. Update on Capital Facilities and Housing

Jane Laciste, Chief, Special Projects, presented an update on Capital Facilities and Housing. She noted that in FY 2004-05, 45% of all MHSA funding was allocated for Capital and 10% has been designated for the following three fiscal years (2005-2008). No money has been spent yet and over that three and a half year period there will be $403 million set aside for Capital Facilities and Technology combined. Beginning in FY 2008-09, there is no longer a specific percentage designation for Capital Facilities.

It is rolled into CSS. Counties can designate up to 20% of their CSS funds for prudent reserves, Capital Facilities and Technology and Education and Training.

Capital Facilities Mission Statement (proposed)

- To support the development of safe, affordable housing and accessible community-based services that enables those with serious mental illness to live in our communities.

Some community organizations may not be able to obtain funds from traditional sources because of their economic and credit status, so this funding could open up new opportunities for the community to expand housing and service options.

Capital Facilities ~ What is the goal?

DMH has been discussing capital facilities for a couple of years and has received substantial input. These are the goals for which DMH seeks further input:

- Increase the number and variety of community-based facilities that support a full continuum of community-based service and living options that offer client choice, promote independence and support integration into the larger community.

- Leverage local, state, and federal resources whenever possible to secure additional funding for client housing and buildings where clients receive services and support.

- Develop long-term accessible and affordable community-based living options.

Previous stakeholder discussions on how Capital Facility funds can be used

Stakeholder groups provided input on how to spend Capital Facilities funds during the 2005 workgroup meeting on housing:

- Separate community-based crisis stabilization and residential facilities for adults and youth
- Co-locate mental health services with primary care clinics
- Promote Family Resource Centers for “one-stop” service with a variety of providers
- Fund facilities for client/peer operated wellness and recovery support centers
- Fund community-based assessment centers
- Fund transitional housing for transition age youth (TAY)
- Provide permanent supportive housing

A more comprehensive list is available on the DMH Website in the summary of the 2005 workgroup meeting on housing.

Proposed Definition of Capital Facilities

- A “capital facility” is a permanent building that is used for the delivery of MHSA services or to meet the housing needs of mental health clients and their families.
- Capital facility funds may be used to acquire, develop or rehabilitate such buildings.

What will it fund? (proposed)

- Acquisition, improvement and development of land
- Construction or renovation of a building or facility
- Other possibilities being considered:
  - Soft costs for development: permit fees, zoning, environmental impact studies or surveys that are part of the upfront costs
  - Operating capital reserves for costs of running it once a facility is operational (plumbing, electrical, vacant units)

The Governor's Executive Order S-07-06 directed the following, acknowledging that good mental health is an integral part of well-being and that many people with mental illness become homeless:

- Up to $75 million per year of the MHSA funds will be dedicated to permanent supportive housing for individuals with mental illness and their families, especially including homeless individuals with mental illness and their families
- The goal is to create 10,000 units of permanent supportive housing across the state

Goal of MHSA Supportive Housing

DMH wants to create housing that supports wellness, recovery and resiliency. Housing is essential to transform the lives of people with mental illness. In order to make this happen, DMH must partner with various agencies that are experts in housing development and related resources. The MHSA Housing Program guidelines are still under development by the technical committee. The technical committee is comprised of:

- DMH
- California Housing and Finance Agency (CalHFA)
- Housing and Community Development (HCD)
- County Mental Health Directors Association (CMHDA)
- Non-profit housing developers
- Corporation for Supportive Housing (CSH)
- Tax Credit Allocation Committee (TCAC)

Core Issues to Consider

- **Who?** Define the target population (especially at risk of homelessness)
- **What?** Define the types of housing (especially any limits/targets)
- **How?** Define funding use (will funds be used for development costs, operating subsidies, etc?)

Next Steps

- Draft guidelines for stakeholder input in late December/early January for both Capital Facilities and Housing
- Following the issue of draft guidelines, hold stakeholder conference calls specifically for input on Capital Facilities and the MHSA Housing Program

- DMH plans to issue final guidelines in early 2007, so that funding can flow to the counties. Every month of delay, the cost of building increases.

Watch for posting of the guidelines:
http://www.dmh.ca.gov/MHSA
How to provide input:
Toll-free line (within California): (800) 972-MHSA (6472)
Email: mhsa@dmh.ca.gov
MHSA
Department of Mental Health
1600 9th Street, Room 250
Sacramento, CA 95814

Specific Stakeholder Feedback on Mission, Goals, Definition and Funding

Proposed Mission Statement
To support the development of safe, affordable housing and accessible community-based services that enable those with serious mental illness to live in our communities.

Stakeholder Feedback on Mission Statement
- What about using Capital Facilities funding for Prevention and Early Intervention?
- Insert "full continuum" to "support the development of safe, affordable" and "full continuum of accessible community-based…" Counties need to ensure all levels of service and supports are available.
- Mental health clients could live at a motel with a restaurant managed by professional care providers.

Proposed Goals
- Increase the number and variety of community-based facilities that support a full continuum of community-based service options that offer client choice, promote independence and support integration into the larger community.

- Leverage local, state, and federal resources whenever possible to secure additional funding for client housing and buildings where clients receive services and support.

- Develop long-term accessible and affordable community-based living options.

Stakeholder Feedback on Goals
- Why reinvent the wheel? Why not adopt Section 8 Housing and Urban Development (HUD) financial guidelines for consumers (not to exceed 30% of monthly income)?
- The goals appear to be more focused on "living options": it is not just living options but also care and supports and service options.
- Do not change "living options" to "supportive options."
- Clarify goal to read "…community-based facilities which support a full continuum of community-based mental health services that offer client choice…" Broaden wording to allow for co-located mental health services with primary care clinics.

- Use aspects of the Fresno County Cedar Heights/Cedar Woods facility as a role model.
- Provide greater incentives to non-profit housing developers to increase the number of developers.

Proposed Definition

- A “capital facility” is a permanent building that is used for the delivery of MHSA services or to meet the housing needs of mental health clients and their families.
- Capital Facility funds may be used to acquire, develop or rehabilitate such buildings.

Stakeholder Feedback on Definition

- What does “permanent” mean? Is it really bricks and mortar? Or does it mean it has to be in existence forever?
- Be more accessible to the underserved population, such as the Southeast Asian community
- First sentence: “used for the delivery of MHSA services” is broad and may mean different things to different people or may not be understood. Add an example or explanation of MHSA services that emphasizes integration with primary care, substance abuse, etc.
- Mobile clinics need to be included for sparsely populated rural areas of many counties

What Will It Fund? (proposed)

- Acquisition, improvement and development of land
- Construction or renovation of a building or facility
- Other possibilities being considered:
  - Soft costs for development: permit fees, zoning, environmental impact studies or surveys that are part of the up-front costs
  - Operating capital reserves for costs of running it once a facility is operational (plumbing, electrical, vacant units)

Stakeholder Feedback on what it will Fund

- Are there workforce development funds for support staff in supportive housing?
- Allow funds for operations costs such as maintenance for cleanliness, pest prevention, security, on-site manager, repairs and utilities
- Fund transition age youth housing and support
- Allow funding for onsite manager to head off problems, oversee the development and answer questions
- Allow funds for security to deter drug selling, thefts and criminal activity
- Fund a space in all capital facilities for meetings, socialization, interaction and games
- Include consumers in the design and plan stages of housing development. Public supported housing is too often so poorly designed that it is unlivable and often has no amenities.

- Back in 1992, HUD allowed people to build their house. It would be nice if this were available to consumers.
- Facilities for school-based programs for special needs students
- Education for people who are homeless because of mental health issues. This could include education on finances, medication management, hygiene and how to obtain services.
- Placement for homeless people who are being released from hospitals
- Build a housing campus with different levels of support. Consumers can transition between different levels, if there are setbacks or advances. The safe and maintained campus would have activities, drop-in center, a place to obtain legal and medical services, pharmacy, job training, jobs working on the campus, peer support, recreational facilities.
- Thank you for adding "facilities for client/peer operated wellness and recovery support centers" and "permanent supportive housing" to the list of suggestions for how these funds should be used.

General Stakeholder Comments and Questions

Consumer Rights and Rules

- **Stakeholder Comment:** Statewide pro bono legal advocacy for clients would be a major advance for clients. This means both a process to access the advocacy and the hiring of or contracting with an advocate.
- **Stakeholder Comment:** Consumers would like fewer regulations. Treat consumers like adults, not children. Give us minimum regulations and give us responsibility that will allow us to grow.
- **Stakeholder Comment:** House rules in supportive housing programs tend to be arbitrarily and discriminatorily enforced. MHSA-funded supportive housing programs in clustered buildings should avoid overly restrictive house rules, particularly those that heavily regulate visitors and visitor "privileges." Instead, residents should be allowed to decide their own set of house rules, including visiting rules. This policy may help increase empowerment and support wellness among client residents who seek to have visitors.
- **Stakeholder Comment:** Landlords and property managers (including "supportive" housing property manager) of housing funded in whole or in part by MHSA monies must be trained in how to provide reasonable accommodations to residents with mental disabilities to prevent evictions in the event their units are cluttered or they are incarcerated or hospitalized for several days and miss a rent payment. Such training will prevent many clients from becoming homeless.
- **Stakeholder Comment:** Consumers need a decent place to live after release from jail or a locked facility.
- **Stakeholder Comment:** Mental health consumers should be a top priority to HUD programs. Some consumers have felony convictions or need help with paperwork.
- **Stakeholder Comment:** Shared supportive housing can create stability. A serious problem in shared housing is "the dog effect" – if one dog is wounded the pack will

kill it. Consumers need structure, rules and programs to help people learn how to live together.

- **Stakeholder Comment:** Target population should extend beyond homeless to transition age youth and people in board and care facilities.
- **Stakeholder Comment:** Provide more clean and livable housing.
- **Stakeholder Comment:** Enhance existing agencies, including patient rights advocates, long term care ombudsman and adult protective services.

Housing Types

- **Stakeholder Comment:** Homes should be scattered. Not every consumer wants to live with all other consumers.
- **Stakeholder Comment:** Consumers living in board and care homes often do not have the option to leave this housing. It is important to have this right. There should also be employment for low-functioning people in board and care.
- **Stakeholder Comment:** From experience and in speaking about this project, cluster housing is the best practice. There is an apartment building in Fresno that is excellent. The rent is reasonable ($200-250), they get free Internet and cable; the facilities are excellent. There is an automatic peer support. They have the support of staff at all times. The county saves substantial funds each year because they do not need a caseworker. It is open, not a prison. The consumers are happy and safe. This development is an apartment complex, bought by NAMI. There are studios and one and two bedroom apartments. The consumers are carefully matched. There is staff on 24/7. Consumers are living independently in a totally safe neighborhood. The SMART technology would work well in an apartment complex.
- **Stakeholder Comment:** There are not enough of these developments.
- **Stakeholder Comment:** This cluster housing is very good, but it appears to be discriminatory, not racial, but it seems you need to know someone to get in.
- **Stakeholder Comment:** Use a large motel with a restaurant and large meeting room. It could be a commune that would be managed by health care providers, like this place.
- **Stakeholder Comment:** All levels of housing are needed. All levels need a new advocacy group to monitor them.
- **Stakeholder Comment:** Add more variety in housing.
- **Stakeholder Comment:** Merced County has a wellness center and there was safe housing. People are stagnating in board and care facilities.

Safety Issues

- **Stakeholder Comment:** Shelter, safety and security equals wellness and recovery. This is paramount for people with mental illness. Each consumer needs secure, supportive housing. Consumers need transitional housing that encourages independent living skills, near transportation.
- **Stakeholder Comment:** In our county, our transitional homes are in the poorest, most unsafe neighborhoods. There should be no threats of drugs or violence.

- **Stakeholder Comment:** Transitional homes can be scary, because consumers have different types of mental illness and some are sometimes out of control. Many consumers cannot afford rent in other places.
- **Stakeholder Comment:** There should be more inspections: some housing facilities are unfit for human habitation.
- **Stakeholder Comment:** Do not overlook the operation of the facility, including security. There are problems with crime and drug sellers.
- **Stakeholder Comment:** In Merced County, there are room and board facilities that are not governed or regulated by anyone. This is a problem for consumers – there is no supervision from the facility. Things happen there that are unsafe for consumers.
- **Stakeholder Comment:** There is not enough safe, supportive housing and no real plan to take immediate steps to remedy the problem.
- **Stakeholder Comment:** Housing is a basic need and must be prioritized in DMH Capital Facilities requirements. Housing must be safe, permanent and affordable. Shelters, transitional housing programs and board and care facilities do not meet these standards and should not be considered "housing" eligible for MHSA funding under the DMH Capital Facilities component. More support is needed for clients who live on their own without assistance. Scattered site housing should be a priority in the DMH Capital Facilities component, rather than clustered housing. No one should have to live in a "mental health ghetto." When possible, housing should be conveniently located near public transit and shopping.

Supportive Housing Needs and Concerns

- **Stakeholder Comment:** Housing should be about choice, not a one-size-fits-all, cookie cutter approach. Clients who seek supportive housing should be able to get housed and stay housed, whether they participate in a treatment program or not. Coercive housing programs that threaten eviction of residents who do not comply should not be permitted under MHSA Capital Facilities component.
- **Stakeholder Comment:** The DMH says it has money for bricks and mortar. The hard part is supportive housing. When DMH puts up the building, what is the coordinated mechanism for supportive housing?
- **Stakeholder Comment:** Consider an onsite manager. This has a better success rate.
- **Stakeholder Comment:** Consumers need long-term housing and stability. Consider client-run housing.
- **Stakeholder Comment:** Client-driven supportive housing, offering residents the option of onsite peer counseling and advocacy, should be a recommended strategy.
- **Stakeholder Comment:** Medication management is difficult for people who are homeless. Time is running out to provide shelter for the homeless this winter.
- **Stakeholder Question:** Will this housing be client-driven supportive housing with peer advocacy?
    - **DMH Response (Jane Laciste (JL)):** That is the goal. It depends on the structure of each project. The underlying need is the same: that services be available 24 hours/7 days a week.
    - **Stakeholder Comment:** Please make it a requirement.

Leveraging Access

- **Stakeholder Question:** There is a huge senior citizen development in Orange County. There used to be set-asides for people with disabilities. Could there be such set-asides for mental health clients for projects such as this?
  - **DMH Response (JL):** DMH is coordinating with CalHFA to work with other agencies that are developing such projects in order to include housing for mental health consumers. DMH is not setting limits, but is reminding counties to provide specialized housing for TAY, older adults and families with children.
- **Stakeholder Question:** Are there set-asides in the law currently for people with disabilities?
  - **Corporation for Supportive Housing (CSH) Response (Ann Reilly (AR)):** Under Fair Housing, a project cannot say that a particular unit is for a particular group. Different funding sources have different restrictions. There is a federal program for senior housing, which has a preference for disabilities. To leverage funding, CSH is working with developers to include mental health clients.
- **Stakeholder Question:** Is there a task force working on the financial eligibility?
  - The technical committee is working on the financing of the project to bring together all the pieces.

- **Stakeholder Question:** How will eligibility work with Section 8?
  - **DMH Response (JL):** This is another question the technical committee is addressing.

Technical Committee Issues

- **Stakeholder Question:** Our community would like to build a crisis house in our area. How does one use these funds and who owns the building when done?
  - **DMH Response (JL):** This is one of the issues the technical committee is exploring. Money could go directly to the nonprofit. The committee is looking at a deed requirement that the nonprofit would house mental health consumers for some extended period of time to assure the building stays in use as defined in the legislation.
- **Stakeholder Comment:** Regarding the option that people can buy vacant land: be careful about this, because it costs a lot of money to build on the vacant land. Housing has the reputation for being a political arena. Keep in mind that stakeholders need housing quickly. The critical need is there. Keep the politics out of the discussion.
- **Stakeholder Question:** The make-up of the technical committee is reasonable, however, would it have been appropriate to have such groups as NAMI, which has developed small housing programs? Is it too late to add such groups?
  - **DMH Response (JL):** Yes, at this point it is too late. There are many issues that are still open, but these issues are very technical, including issues of tax credits. Once the committee can get these technical details addressed, the product will be vetted with stakeholder groups.

Terminology

- **Stakeholder Comment:** The description of housing in projects sounds like DMH wants to put consumers in a project, with all the negative connotations that brings. It brings chills. Consumers want to be in the community.
  - **DMH Response (JL):** No, DMH means the project for creating the housing, not housing projects for consumers.
- **Stakeholder Comment:** When referencing primary care clinics, this is a specific category within the state licensing structure. It would be better to call them health care clinics, rather than primary care clinics.
- **Stakeholder Question:** Is the $75 million the Governor is giving each year statewide?
  - **DMH Response (JL):** The funding is not coming from the Governor; rather the Governor has ordered that $75 million of the money in the Mental Health Services Fund be directed to housing.
- **Stakeholder Comment:** Redefine the term "supportive." Housing needs to be a choice.

Financial and Fairness Issues

- **Stakeholder Comment:** There needs to be equality in housing: some people get nice places, others less so.
- **Stakeholder Comment:** Have mixed income housing, not just for consumers on SSI.
- **Stakeholder Comment:** Do not look just at the homeless or near homeless. Consumers on SSI cannot afford rent increases.
- **Stakeholder Comment:** Consider making housing "smart" homes for electricity and heat systems. This is a safety issue. It is also a cost issue.
- **Stakeholder Comment:** Counties are implementing CSS right now. It would be best to have housing funding to support CSS.

Stakeholder Input in Housing Issues

- **Stakeholder Comment:** There should be an open door for input from consumers. If DMH or counties are putting together a development, have an open meeting that consumers can get to in order to obtain their input.
- **Stakeholder Comment:** Require an open forum in a central, accessible location for input from consumers and family members.
- **Stakeholder Comment:** Include the consumer's family in planning and case conferences when moving to a new level of care.

Capital Facilities for Services

- **Stakeholder Question:** It is heartening to see physical and mental health both on these potential funding options. The slides however mention only living options. Were service options omitted intentionally?
  - **DMH Response (JL):** Service options should be included as well. The slide will be revised.
- **Stakeholder Question:** Is there a similar committee working on Capital Facilities for service providers?

- **DMH Response (JL):** No.

V. Update on MHSA Funding: Focus on Revenues

Carol Hood, Deputy Director, presented information about MHSA financing. The funding comes entirely from a 1% tax on personal income in excess of $1 million, which is approximately $1 billion a year. DMH will be developing official projections twice a year with the Governor's Budget in January and the May Budget Revise.

The budgeting and planning are complex because of the timing of revenues. The revenue is generated from cash transfers, which come either twice a month for income tax withholding or quarterly for investment or interest income. The actual money comes when people file their taxes on April 15 and more when final returns are filed on October 15. For income earned in 2005, the final income tax filings were not made until October 15, 2006, so there could be no final accounting until now. Meanwhile, the state deposits 1.76% of personal income tax into the Mental Health Services Fund twice a month, based on the estimate of the percentage the millionaires' 1% of income will be. The State invests the deposited money, which earns interest, so there are quarterly deposits. The final reconciliation will not be known until the Department of Finance has the time to analyze what was deposited compared to what was actually earned. DMH will not know the actual 2005 funding until March 2007. Although money was deposited throughout 2005 and 2006, an adjustment will likely need to be made. If not enough was deposited, the State will make a lump sum payment on July 1. If too much was deposited, the State will withhold funds until the money is paid back.

It is important to note that the fluctuations in the economy can change the amount of tax collected by as much as 65% from one year to the next, so DMH wants to be conservative in its estimates in order not to fund programs for which there will be insufficient funds in future years.

Estimated Funds for Mental Health Services Fund
For Community Services and Supports

In Millions	FY 05/06	FY 06/07	FY 07/08
Planning Estimate	$317.3	$320.4	$339.3
Cash transfers	$465	$478.6	$383.0
Accrued revenue			$154.1
Interest	$6.4	$7.4	$15.7
Revised total	$471.4	$486.0	$552.8

When Will Expansion Occur?
Principles

- Planning estimates based on actual cash, not estimate
- Consider sustainability when establishing planning estimates

The target for the reserve for Community Services and Supports is $365 million. It can be used during economic downturns to maintain consistent service levels. Counties may also establish an operating reserve locally of 10% for unexpected expenses.

Each July, DMH will review projections for the prior May and establish a new planning estimate for the following year. There will be a new planning estimate in December 2006 that is expected to include at least $100 million in expansion for CSS. In future years, DMH hopes to make this planning estimate in July. The estimate will be shown for each separate component of MHSA. The planning estimate will be based on actual cash earned. The estimate will also provide the maximum each county can apply for, and their contracts will provide for approved amounts.

FY 2006/07 and FY 2007/08
Criteria for Expansion of Services

- DRAFT Process – counties may request funding
- Expansion of existing, approved programs
- No new program description
- Budget based on approved cost per client
- Ensure capacity
- Add new programs
- Must have been through stakeholder process
- Meet same CSS narrative and budget requirements
- 30 day period for stakeholder review required

Cash Balance Report

- Twice a year, counties will report cash availability
- Local cash reserves can total:
  - 10% operating reserve
  - One quarter's operating costs
  - One-time project funding
  - If additional is cash available, county quarterly distributions will be reduced

Future Development

- Allowable expenditures for balance of components. For example, are rent subsidies a cost under CSS or Capital Facilities?
- Interpretation of requirement that 20% limit for Capital, Technology, Education and Training and Prudent Reserve beginning in FY 08/09
- Prudent reserve level for other components
- Format for public reporting of expenditures
- Planning estimates for balance of components

Stakeholder Comments and Questions

Funding

- **Stakeholder Question:** Consumers in Fresno felt cheated in the realignment process. For this MHSA expansion, use the same process as the original distribution for MHSA.

- **DMH Response (Carol Hood (CH)):** Counties will apply for the money within the planning estimate established for each county. DMH and the County Mental Health Directors Association have only recently agreed to the principles.

- **Stakeholder Question:** This funding is not enough money to meet the need. The Department of Corrections is collecting more money than MHSA for a system that fails. MHSA funds will only address the tip of the iceberg of problems.
  - **DMH Response (CH):** Most people in the mental health field agree that MHSA funding is not enough. DMH has to show that MHSA can make a difference in outcomes. The State will have to demonstrate that MHSA will make a difference.
- **Stakeholder Comment:** Consumers on SSI may get as little as $866 a month, and cannot afford to pay much rent. Many are and have been homeless and it is very ugly out there on the streets. Many consumers have been ostracized because their families could not handle their mental illness.
- **Stakeholder Question:** It appears that counties are focusing the Medi-Cal drawdown rather than providing services. Please help with this.
  - **DMH Response (CH):** DMH can be a piece of the solution to this concern. There is no legal reason not to draw down Medi-Cal, but it cannot be a driver of the system. The consumers need to be involved in advocacy efforts to address this.
- **Stakeholder Question:** Set aside a percentage of funds to advertise these meetings. People without computers cannot receive the summaries.
  - **DMH Response (CH):** DMH mails hard copies of all on-line postings for people who prefer to receive it that way. Give your name to DMH staff.
- **Stakeholder Question:** What happens when a project does not happen within the specified time frame in terms of access to their county estimate?
  - **DMH Response (CH):** Estimates are based on the Governor's Budget and the May Revise of the budget. MHSA does not depend on legislative approval, so it can happen more smoothly.
- **Stakeholder Question:** What is the oversight agency's responsibility in assuring the money is used properly? Are there laws to protect this money? Our county can be creative about using funds. How can we make sure the funds are protected?
  - **DMH Response (CH):** The two oversight bodies are DMH and Oversight and Accountability Commission (OAC), both of which can be found on the MHSA Website. The OAC is appointed primarily by the Governor. There will be audits by both DMH and the OAC's finance and audit committee.
- **Stakeholder Question:** If there is more money, please invest it in state oversight of the process. Consumers have been edged out of the process. There have been no reimbursements for consumers to participate.
  - **DMH Response (CH):** There was a meeting yesterday with the CMHDA at which the Client Network, NAMI and parents made presentations. It looks like there will be change. DMH is working on getting the resources for oversight.
- **Stakeholder Question:** Are there any legal challenges to MHSA?
  - **DMH Response (CH):** There have been none up until now and none are pending that DMH is aware of. There were some talk of challenges in the beginning, but nothing came of them.

Other Stakeholder Issues

Grievances

- Consumers need to have a place in the state to file grievances
- DMH must establish a formal grievance process by which clients may address issues of improper MHSA implementation practices, exclusion and discrimination in their counties
- DMH must hear clients' complaints of improper MHSA implementation practices in a timely manner
- DMH must follow-up on any and all such complaints, and when there is clear evidence that a county has violated one or more DMH regulations, enforce the appropriate regulations

Consumer Involvement and Reimbursement

- In many counties, ever since the initial MHSA planning process ended, clients have been told that there will be no travel reimbursements to attend ongoing planning meetings
- Provide reimbursements for consumers to participate in MHSA
- There has been an overall lack of client representation and involvement on important county MHSA committees; all too often, clients are entirely absent from key MHSA decision-making bodies.
- In many counties, there has also been little or no advance notification for MHSA meetings
- County MHSA meetings are frequently held in locations that are inaccessible to buses or public transportation, when more accessible meeting locations are available
- Client involvement in every aspect and at every level of MHSA planning, implementation, oversight and evaluation are written into the act and into the CSS plan requirements. DMH needs to enforce this requirement.
- Counties' failure to reimburse clients for travel costs, combined with the overall lack of client representation on key MHSA committees, the lack of advance notice of meetings and the inaccessible locations have resulted in the de facto exclusion of many clients from MHSA planning and implementation.
- Consumers want client involvement in the MHSA process. Consumers want to have a voice in the new movement of MHSA for implementation to change the system into an equal rights process in all counties.
- That the attitude and stigma is prevalent throughout the mental health field is evident in the planning of this meeting. DMH says it wants consumer input. It is almost impossible for consumers to come to this meeting. There is a stigma even for the organizers. Consumers must contend with the pervasive patronizing attitude.

Oversight

- DMH must monitor local MHSA planning and implementation more closely.
- Consumers want documentation to hold counties accountable for what they are doing in reforming, transforming and supporting collaboration in the communities.

Consumer Support and Services

- Mental health services such as housing, health care, day care programs seem to all require that the consumer have SSI. MHSA funds should be allocated to provide help for consumers to qualify for and secure their SSI. The paperwork and enrollment process operate on a much higher level of cognition than most consumers have. This will help consumers to access mental health services.
- Keep in mind that consumers are people too and need socialization and the interpersonal skills to meet and interact with their peers. Social anxiety is a common diagnosis amongst mental health consumers. Consumers also need to feel useful. Help them find and keep some form of work or project to apply themselves in spite of their symptoms or pacing, lack of concentration, irritability, untimeliness and memory loss. Self esteem, dignity and self-respect are also needed by consumers to achieve wellness.
- There is a need for programs for people with cerebral palsy and other disabilities.
- Consumers want and need peer support in order to harness the passion that comes from recovery in a supportive environment with someone who knows what their experience is like.
- 80% of people in prison are there because of drugs, 90% of those are self-medicating and a large percentage of those are self-medicating because of mental illness. Keep this information in mind so that MHSA can be used to pull those people out of the dark ages of incarceration. Abstinence is not the only method; advocates support harm reduction as well. To achieve this, mental health issues must be addressed.
- Consumers want to decrease the stigma and discrimination of all types of ethnic groups including Latinos.
- A concern for Latinos is shared housing and having no say in how the counties are serving consumers. Because of MHSA, mental health agencies no longer have to match Medi-Cal dollars to clients and this can lead to transformation. Consumers are not all like Linus in Peanuts: they do not all sit there with a security blanket and wait for services. Rather, many are angry, which can make people afraid, but with the right services, consumers can change and this will make the system change. Consumers can be there for each other, which will bring more people into services and support. Consumers are asking counties daily to stop giving false hope and start programs to help everyone.
- There needs to be more recreational activities for consumers through drop-in centers.
- Many women are afraid of conservatorships, because they are afraid to lose their children. Do consumers really matter to the county, state and providers?

Provider and Staff Training Needs

- It is important to have education and training of the staff and doctors to really listen to their clients. Providers generally do not listen and miss important life-threatening issues. Consumers want to be heard.
- Provide cultural sensitivity training to all providers as well as clerical staff and receptionists. Orient staff to the fact that often consumers need simple language and help with paperwork.

- If people disagree with their providers, they are medicated. Clients are like dirt to providers. Providers control their clients' lives through medication.

VI. Review of Upcoming Workgroup Meetings and Evaluation

The currently scheduled meetings on December 5 and 6, 2006 have been postponed to February 6 and 9, 2007. These meetings will address Prevention and Early Intervention.